NEW MEXICO DEPARTMENT OF HEALTH

EMS FUND ACT
VEHICLE PURCHASE APPLICATION
FOR FISCAL YEAR 2019

Due Date: November 17, 2017

FOR BUREAU USE ONLY (do not write in this area)				
Date Received	**Region**	**Statues**	**Reviewer**	**Disposition**

Name of Recipient ➔ *(EMS Service/Agency)*		
Address ➔		
Contact Person ➔		
Telephone #	Fax #	Email

Fiscal Agent ➔ *(County or Municipality)*		
Address ➔		
Contact Person ➔		
Telephone #	Fax #	Email

A. Detailed Analysis of Problem and Need:

Describe in **detail** the existing problem, and the **need & rational** for this new or replacement EMS vehicle and its relationship to your operational mission. This will include the number and type of calls, the **condition** of current vehicle(s), service area characteristics, etc. **If you are proposing a Non-Transport EMS vehicle, please provide details and rationale.**

B. Service Area Description:

Describe the existing EMS System for which this vehicle would be responding. Information should include a complete service area description, organization of the system, and which services are involved (responding units, rescues, ambulances, hospital, etc). Provide as much detail as possible regarding your current system, along with Mutual Aid agreements. (Attach additional sheets if necessary)

C. Project Impact:

Please describe the impact obtaining this vehicle will have on your EMS System and your county's other EMS services. Also, describe the priority ranking that this request received in the EMS Vehicle Assessment Form. (Attachment #1 to this application)

D. Cost of Project:

Identify the specification for the EMS vehicle that you propose to purchase (i.e., Ambulance, Type I, Light Duty Cab/Chassis with rear wheel and transferable modular body; Ambulance, Type III, Medium Duty, 4X4, etc.). Provide the specifications and cost estimate*.

*The itemized expense report/estimate for this purchase, including the 25% matching funds, other contributions, and the source of these funds, MUST be provided.

Estimated Purchase Price (Base Unit with no custom features)	$ _____ Base Price
Custom features should be itemized on specs/estimate and provided with this application:	$ _____ Custom Price
Amount and source of 25% Matching Funds (of base price) (MUST be provided)	$ _____ 25% Matching Funds _____ Source of Matching funds
Amount Requested from **Fund Act** (No more than 75% of Base price of a unit can be funded)	$ _____

E. Letters of Collaboration/Support:

Letters of support from other services, entities, and stakeholders greatly strengthen the application. Each service's, entities, or stakeholder's support should be expressed in **3 or more separate letters**, **NO DUPLICATES.**

All letters of support must be included with this application.
Letters will not be accepted once the application is submitted.

F. Accountability of Previously Funded Special Project:

Has this service been awarded special funding (i.e., Trauma Systems, Vehicle, Local or Statewide) within the last 3 years? Please describe the status/outcome of the funded project/vehicle. **Failure to accurately disclose this information will disqualify the application.**

FY of Award	Amount	Name of Project/Description	Status

ASSURANCES
FY 19 EMS Vehicle Purchase Program

- I certify that all operational and equipment costs associated with this vehicle will be provided for, and;
- I certify that the **required matching funds of at least 25% is now or will be available**, and;
- I certify that the vehicle will be purchased according to the NM State Procurement Code, and;
- I certify that the local recipient and applicant understand and agree to comply with any and all applicable requirements and regulations of the New Mexico Department of Health, and;
- I certify that the information contained in this application is true and correct to the best of my knowledge.

Chief / Director of Local EMS Service

NAME: _____ (Print / Type Name) TITLE: _____

SIGNATURE: _____ DATE: _____

The above was sworn and subscribed to before me this ____ (Day) of _____ (Month), 20_____

_____ -
Notary Public

My commission expires: _____

(SEAL)

Mayor / Chairman County Commission

NAME: _____ (Print / Type Name) TITLE: _____

SIGNATURE: _____ DATE: _____

The above was sworn and subscribed to before me this ____ (Day) of _____ (Month), 20_____

_____ -
Notary Public

My commission expires: _____

(SEAL)

EMS Agency Name: _____

- **For applications requesting a vehicle that will serve as a replacement, please provide the unit number of the vehicle targeted for replacement, a summary of the area serviced by this vehicle, and why it needs replacement. While this application is obviously for one potential replacement vehicle, please list all EMS vehicles in most need of replacement.**

- **If this application is for a new vehicle, provide a summary of the area to be serviced by the new vehicle, and a summary of the reason that potential new/additional vehicle is needed.**

- **We realize this seems redundant, but this sheet serves as a quick reference for the Statewide EMS Advisory Committee review group, as well as other reviewers.**

Vehicle Unit Number	Area Serviced	Reason for Replacement/Additional Unit
1.		
2.		
3.		

- **Please list ALL vehicles used for EMS response in your EMS System/County, including any needing replacement already listed above. Failure to complete this portion will disqualify your application.**

Vehicle Unit Number	Garage Address	Vehicle Make/Model	Year	Type	License Number	2 or 4 wheel dr.	Patient Capacity	Mileage
1.								
2.								
3.								
4.								
5.								
6.								

Regional Office and Service Checklist

1.	All signatures on proper signature lines	Region Initial		Service Initial	
2.	All price quotes attached, if applicable				
3.	All Letters of Support				
4.	All notary signatures in proper place				
5.	All detailed contributions listings				
6.	All services or counties listed that this will benefit				
7.	Letter and approval of extension if needed				
8.	Fiscal agent's correct mailing address				
9.	Recipient's correct mailing address				
10.	Original and 2 additional copies-No special binding.				

Regional Office Reviewer

NAME: _____ TITLE: _____

(Print / Type Name)

SIGNATURE: _____ DATE: _____